

<i>SERFF Tracking Number:</i>	<i>PALD-126375439</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pacific Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44173</i>
<i>Company Tracking Number:</i>	<i>P10IRT</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>P10IRT</i>		
<i>Project Name/Number:</i>	<i>P10IRT/P10IRT</i>		

Filing at a Glance

Company: Pacific Life Insurance Company

Product Name: P10IRT

TOI: L04I Individual Life - Term

SERFF Tr Num: PALD-126375439 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 44173

Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life

Co Tr Num: P10IRT

State Status: Approved-Closed

Filing Type: Form

Author: Jill Dease

Date Submitted: 11/23/2009

Reviewer(s): Linda Bird

Disposition Date: 12/01/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: 02/01/2010

Implementation Date:

State Filing Description:

General Information

Project Name: P10IRT

Project Number: P10IRT

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 12/01/2009

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 12/01/2009

Deemer Date:

Created By: Jill Dease

Submitted By: Jill Dease

Corresponding Filing Tracking Number: P10IRT

Filing Description:

November 23, 009 NAIC # 00067466

FEIN # 95-1079000

Mr. John Shields

Policy Form Filings, Life

Arkansas Department of Insurance

1200 W. Third Street

<i>SERFF Tracking Number:</i>	<i>PALD-126375439</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pacific Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44173</i>
<i>Company Tracking Number:</i>	<i>P10IRT</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>P10IRT</i>		
<i>Project Name/Number:</i>	<i>P10IRT/P10IRT</i>		

Little Rock, AR 72201-1904

Re: Form P10IRT, Monthly Benefit Term Life Insurance
 Form R10ALB, Accelerated Living Benefit Rider
 Form A10TRM, Application for Term Life Insurance
 Form A10TIA, Temporary Insurance Agreement
 Form A10TPF, Foreign Residence/Past and Future Foreign Travel Questionnaire

Dear Mr. Shields,

We are submitting the above referenced individual life insurance forms for your approval. These are new forms that do not replace any previously approved forms. These new forms are being submitted in Nebraska, our state of domicile, and in all other states where Pacific Life is licensed which require such filing. Form P10IRT is a term life insurance policy that pays a death benefit as a monthly benefit for a fixed period. All premiums are guaranteed and the policy is renewable to age 95. Premiums are level to age 65, or for 10 years if longer, then increase annually thereafter. There are 2 monthly benefit options available in the policy: one with a level monthly benefit during the benefit period and the other with a 3% increasing monthly benefit during the benefit period. For both options, the initial monthly benefit can vary depending on the policy year in which the insured dies. The applicant will elect one or the other of these options in the application. The sample policy enclosed has brackets on the policy specifications pages that show the table of initial monthly benefits and there is a sample table for each option. The issued policy will display only the table for the option elected (level or increasing). Form R10ALB is an Accelerated Living Benefit Rider available with the policy. Application form A10TRM is the application to be used with the referenced policy, and can also be used with previously approved term insurance policy P08TRM, approved 2/13/2008. Form A10TIA is a Temporary Insurance Agreement that has been revised to accommodate this new product now being filed. Form A10TPF is a foreign residence and travel questionnaire. The last two forms can be used with any application, as needed.

The following pertain to this submission:

- Actuarial Memorandum is included.
- The policy will NOT be illustrated, so an Illustration Actuary's Certification and sample illustration are not applicable and are therefore not enclosed.
- The forms satisfy any relevant readability requirements (any required certification is enclosed), with Readability scores of 50.7, 53.1, 50.2, 51.8, and 51.2, respectively.
- Policies are sex distinct except those subject to the Norris vs. Arizona decision, which will be issued unisex.
- These forms will be marketed through our licensed agents. The target release date is 3/1/10, or upon approval.
- If a filing fee is required, it is handled in the usual manner. Issue ages are 20-75.
- Where required, a sample Statement of Policy Costs and Benefits is included.
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SERFF Tracking Number: PALD-126375439 State: Arkansas
Filing Company: Pacific Life Insurance Company State Tracking Number: 44173
Company Tracking Number: P10IRT
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: P10IRT
Project Name/Number: P10IRT/P10IRT

- This policy is intended to be used with the following rider/endorsement previously approved in your state as shown:
- R08TPW Premium Waiver Rider Approved: 2/13/2008
- E08UNI Unisex Endorsement Approved: 11/13/2007

To the best of my knowledge and belief this filing complies with the laws and regulations of your state. If you would like to discuss any aspect of this filing, please feel free to contact me at (800) 800-7681, extension 7081 or at jill.dease@pacificlife.com.

Sincerely,

Jill Dease
Senior Compliance Analyst, Product Compliance, Life Division

Company and Contact

Filing Contact Information

Jill Dease, Compliance Analyst Jill.Klinger@pacificlife.com
45 Enterprise Drive 949-420-7081 [Phone]
Aliso Viejo, CA 92656 949-420-7424 [FAX]

Filing Company Information

Pacific Life Insurance Company CoCode: 67466 State of Domicile: Nebraska
45 Enterprise Drive Group Code: 709 Company Type:
Aliso Viejo, CA 92656 Group Name: State ID Number:
(949) 420-7080 ext. [Phone] FEIN Number: 95-1079000

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation: \$50.00 per filing when policy is being submitted
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pacific Life Insurance Company	\$50.00	11/23/2009	32260773

SERFF Tracking Number:	PALD-126375439	State:	Arkansas
Filing Company:	Pacific Life Insurance Company	State Tracking Number:	44173
Company Tracking Number:	P10IRT		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name:	P10IRT		
Project Name/Number:	P10IRT/P10IRT		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/01/2009	12/01/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	11/30/2009	11/30/2009	Jill Dease	11/30/2009	11/30/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Foreign Residence/Past and Future Foreign Travel Questionnaire	Jill Dease	11/30/2009	11/30/2009

SERFF Tracking Number: *PALD-126375439*

State: *Arkansas*

Filing Company: *Pacific Life Insurance Company*

State Tracking Number: *44173*

Company Tracking Number: *P10IRT*

TOI: *L04I Individual Life - Term*

Sub-TOI: *L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life*

Product Name: *P10IRT*

Project Name/Number: *P10IRT/P10IRT*

Disposition

Disposition Date: 12/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PALD-126375439 State: Arkansas

Filing Company: Pacific Life Insurance Company State Tracking Number: 44173

Company Tracking Number: P10IRT

TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life

Product Name: P10IRT

Project Name/Number: P10IRT/P10IRT

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Application Package		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Disclosure Statements		Yes
Form	Monthly Benefit Term Life Insurance		Yes
Form	Accelerated Living Benefit Rider		Yes
Form	Application for Term Life Insurance		Yes
Form	Temporary Insurance Agreement		Yes
Form (<i>revised</i>)	Foreign Residence/Past and Future		Yes
	Foreign Travel Questionnaire		
Form	Foreign Residence/Past and Future	Replaced	Yes
	Foreign Travel Questionnaire		

SERFF Tracking Number: *PALD-126375439* *State:* *Arkansas*
Filing Company: *Pacific Life Insurance Company* *State Tracking Number:* *44173*
Company Tracking Number: *P10IRT*
TOI: *L04I Individual Life - Term* *Sub-TOI:* *L04I.213 Specified Age or Duration -*
 Fixed/Indeterminate Premium - Single Life

Product Name: *P10IRT*
Project Name/Number: *P10IRT/P10IRT*

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 11/30/2009
Submitted Date 11/30/2009
Respond By Date 12/30/2009

Dear Jill Dease,

 This will acknowledge receipt of the captioned filing.

Objection 1

 - Accelerated Living Benefit Rider, R10ALB (Form)

Comment: The Accelerated Benefit Rider issued with life insurance policies require a disclosure statement as outlined in Rule and Regulation 60s8.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

SERFF Tracking Number: PALD-126375439 State: Arkansas
Filing Company: Pacific Life Insurance Company State Tracking Number: 44173
Company Tracking Number: P10IRT
TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: P10IRT
Project Name/Number: P10IRT/P10IRT

Response Letter

Response Letter Status Submitted to State
Response Letter Date 11/30/2009
Submitted Date 11/30/2009

Dear Linda Bird,

Comments:

Thank you for your review of this filing.

Response 1

Comments: I have attached the disclosure document that is provided when the client opts to add the Accelerated Benefit rider.

Related Objection 1

Applies To:

- Accelerated Living Benefit Rider, R10ALB (Form)

Comment:

The Accelerated Benefit Rider issued with life insurance policies require a disclosure statement as outlined in Rule and Regulation 60s8.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Disclosure Statements

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Jill Dease

SERFF Tracking Number: PALD-126375439 State: Arkansas
Filing Company: Pacific Life Insurance Company State Tracking Number: 44173
Company Tracking Number: P10IRT
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name: P10IRT
Project Name/Number: P10IRT/P10IRT

Amendment Letter

Submitted Date: 11/30/2009

Comments:

I have attached a different travel questionnaire because it was brought to my attention that the address in the upper left corner of the form was not bracketed in the original. I have bracketed this information so that should the operations center or telephone information change in the future, we do not have to re-file each form. I apologize for the inconvenience.

Thank you,
Jill Dease

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
A10TPF	Other	Foreign Residence/Past and Future Foreign Travel Questionnaire	Initial				51.200	A10TPF.pdf

SERFF Tracking Number: PALD-126375439 State: Arkansas

Filing Company: Pacific Life Insurance Company State Tracking Number: 44173

Company Tracking Number: P10IRT

TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life

Product Name: P10IRT

Project Name/Number: P10IRT/P10IRT

Form Schedule

Lead Form Number: P10IRT

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	P10IRT	Policy/Cont	Monthly Benefit Term Initial ract/Fratern Life Insurance al Certificate			50.700	P10IRTAR.pdf
	R10ALB	Policy/Cont	Accelerated Living Initial ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider			53.100	R10ALB.pdf
	A10TRM	Application/	Application for Term Initial Enrollment Life Insurance Form			50.200	A10TRM.pdf
	A10TIA	Application/	Temporary Insurance Initial Enrollment Agreement Form			51.800	A10TIA.pdf
	A10TPF	Other	Foreign Initial Residence/Past and Future Foreign Travel Questionnaire			51.200	A10TPF.pdf



PACIFIC LIFE

Pacific Life Insurance Company • 45 Enterprise Drive • Aliso Viejo, CA 92656

READ YOUR POLICY CAREFULLY. This is a legal contract between you, the Owner, and us, Pacific Life Insurance Company, a stock insurance company. We agree to pay the benefits of this policy according to its provisions. The consideration for this policy is the application for it, a copy of which is attached, and payment of the initial and subsequent premiums.

The method for determining the Death Benefit is described in the Death Benefit section of this policy.

Required premium payments must be made in order to keep the policy In Force.

Signed for Pacific Life Insurance Company,

President and Chief Executive Officer

Secretary

MONTHLY BENEFIT TERM LIFE INSURANCE

- **Death Benefit Payable If the Insured Dies During the Coverage Period**
- **Coverage Period to Age 95**
- **Death Benefit Payable as a Monthly Benefit for the Duration of the Benefit Period**
- **Premiums Payable as Provided Herein**
- **Non-Participating**
- **Non-Convertible**

INSURED:	[LELAND STANFORD]	INITIAL MONTHLY BENEFIT*:	[\$5000.00]
SEX AND AGE:	[MALE 35]	INITIAL TOTAL [MONTHLY] PREMIUM:	[\$120.78]
RISK CLASS:	[STANDARD NONSMOKER]	COVERAGE PERIOD:	SEE DEFINITIONS SECTION
POLICY NUMBER:	[1AXXXXXXXX]	BENEFIT PERIOD:	SEE DEFINITIONS SECTION
POLICY DATE:	[OCTOBER 1, 2009]	OWNER:	[LELAND STANFORD]

*This is the Initial Monthly Benefit if the Insured dies in the first policy year. If the Insured dies thereafter, and if the policy is In Force, the Monthly Benefit is described in the Policy Specifications and will not be less than this Initial Monthly Benefit.

Free Look Right - You may return this policy within [20] days after you receive it. To do so, deliver it or mail it to us or to the Insurance Professional who delivered it to you. This policy will then be deemed void from the beginning and we will refund any premium paid.

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POLICY SPECIFICATIONS

BASIC COVERAGE: MONTHLY BENEFIT TERM LIFE INSURANCE

REQUESTED PREMIUM PAYMENT INTERVAL: [MONTHLY]

INITIAL TOTAL [MONTHLY] PREMIUM: \$[120.78]

LEVEL PREMIUM PERIOD END DATE: [OCTOBER 1, 2039]

EXPIRATION DATE (ATTAINED AGE 95): [OCTOBER 1, 2069]

THE PREMIUMS SHOWN ON THE FOLLOWING PAGES ARE FOR ANNUAL PAYMENTS. PREMIUMS CAN BE PAID MORE FREQUENTLY THAN ANNUALLY, BUT THE TOTAL AMOUNT PAID EACH YEAR WILL BE GREATER THAN WHEN PAID ANNUALLY. TO CALCULATE THE PREMIUM DUE FOR OTHER MODES OF PAYMENT, MULTIPLY THE BASIC COVERAGE PREMIUM [if Premium Waiver is included, add "PLUS THE PREMIUM WAIVER RIDER PREMIUM"] BY THE APPROPRIATE FACTOR BELOW AND ROUND TO THE NEAREST \$0.01:

0.510 FOR SEMI-ANNUAL PREMIUMS

0.265 FOR QUARTERLY PREMIUMS

0.090 FOR THE MONTHLY PRE-AUTHORIZED CHECK PAYMENT PLAN

POLICY SPECIFICATIONS

SUMMARY OF COVERAGES EFFECTIVE ON THE POLICY DATE

P10IRT	BASIC COVERAGE	
	MONTHLY BENEFIT:	SEE TABLE OF INITIAL MONTHLY BENEFITS
	INSURED:	[LELAND STANFORD]
	SEX AND AGE:	[MALE 35]
	RISK CLASS:	[STANDARD NONSMOKER]

[R10ALB	ACCELERATED LIVING BENEFIT RIDER]
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POLICY SPECIFICATIONS

TABLE OF PREMIUMS AT ANNUAL INTERVALS
FOR BASIC COVERAGE

INSURED: [LELAND STANFORD]

POLICY YEAR	ANNUAL PREMIUMS*
1	\$[1,342.05
2	1,342.05
3	1,342.05
4	1,342.05
5	1,342.05
6	1,342.05
7	1,342.05
8	1,342.05
9	1,342.05
10	1,342.05
11	1,342.05
12	1,342.05
13	1,342.05
14	1,342.05
15	1,342.05
16	1,342.05
17	1,342.05
18	1,342.05
19	1,342.05
20	1,342.05
21	1,342.05
22	1,342.05
23	1,342.05
24	1,342.05
25	1,342.05
26	1,342.05
27	1,342.05
28	1,342.05
29	1,342.05
30	1,342.05
31	8,930.98
32	9,810.09
33	10,700.60
34	11,659.64
35	12,652.87
36	13,857.36
37	15,204.55
38	16,974.17
39	18,840.84
40	20,804.55

*THE PREMIUMS SHOWN ABOVE INCLUDE A \$100 POLICY FEE.

POLICY NUMBER [1AXXXXXXXX]

POLICY SPECIFICATIONS

TABLE OF PREMIUMS AT ANNUAL INTERVALS
FOR BASIC COVERAGE
(CONTINUED)

INSURED: [LELAND STANFORD]

POLICY YEAR	ANNUAL PREMIUMS*
41	\$22,950.92
42	25,291.38
43	28,008.60
44	31,182.54
45	34,847.34
46	38,843.26
47	43,392.90
48	48,130.91
49	53,239.95
50	58,897.04
51	65,216.29
52	72,220.57
53	79,869.89
54	88,067.21
55	96,715.54
56	105,740.57
57	114,229.04
58	123,077.13
59	132,410.48
60	142,268.97]

*THE PREMIUMS SHOWN ABOVE INCLUDE A \$100 POLICY FEE.

POLICY SPECIFICATIONS

[TABLE OF INITIAL MONTHLY BENEFITS

{Note: Sample is for Level Monthly Benefit}
 INSURED: [LELAND STANFORD]

IF INSURED'S DATE OF DEATH IS IN POLICY YEAR	INITIAL MONTHLY BENEFIT WILL BE
1	\$[5,000.00
2	5,000.00
3	5,000.00
4	5,000.00
5	5,000.00
6	5,000.00
7	5,000.00
8	5,000.00
9	5,000.00
10	5,000.00
11	5,000.00
12	5,000.00
13	5,000.00
14	5,000.00
15	5,000.00
16	5,000.00
17	5,000.00
18	5,000.00
19	5,000.00
20	5,000.00
21	5,000.00
22	5,000.00
23	5,000.00
24	5,050.00
25	5,250.00
26	5,350.00
27	5,350.00
28	5,350.00
29	5,350.00
30	5,350.00
31	5,350.00
32	5,350.00
33	5,350.00
34	5,350.00
35	5,350.00
36	5,350.00
37	5,350.00
38	5,350.00
39	5,350.00
40	5,350.00

Following the Insured's death, the Monthly Benefit amount will remain level during the Benefit Period.

POLICY SPECIFICATIONS

TABLE OF INITIAL MONTHLY BENEFITS

{Note: Sample is for Level Monthly Benefit}
 INSURED: [LELAND STANFORD]
 (CONTINUED)

IF INSURED'S DATE OF DEATH IS IN POLICY YEAR	INITIAL MONTHLY BENEFIT WILL BE
41	\$5,350.00
42	5,350.00
43	5,350.00
44	5,350.00
45	5,350.00
46	5,350.00
47	5,350.00
48	5,350.00
49	5,350.00
50	5,350.00
51	5,350.00
52	5,350.00
53	5,350.00
54	5,350.00
55	5,350.00
56	5,350.00
57	5,350.00
58	5,350.00
59	5,350.00
60	5,350.00]

Following the Insured's death, the Monthly Benefit amount will remain level during the Benefit Period.]

POLICY SPECIFICATIONS

[TABLE OF INITIAL MONTHLY BENEFITS

{Note: Sample is for 3% Increasing Monthly Benefit}
 INSURED: [LELAND STANFORD]

IF INSURED'S DATE OF DEATH IS IN POLICY YEAR	INITIAL MONTHLY BENEFIT WILL BE
1	\$[5,000.00
2	5,150.00
3	5,304.50
4	5,463.65
5	5,627.55
6	5,796.35
7	5,970.25
8	6,149.35
9	6,333.85
10	6,523.85
11	6,719.60
12	6,921.15
13	7,128.80
14	7,342.65
15	7,562.95
16	7,789.85
17	8,023.55
18	8,264.25
19	8,512.15
20	8,767.55
21	9,030.55
22	9,301.45
23	9,580.50
24	9,867.95
25	10,367.25
26	10,678.25
27	10,998.60
28	11,328.55
29	11,668.45
30	12,018.50
31	12,379.05
32	12,750.40
33	13,132.90
34	13,526.90
35	13,932.70
36	14,350.70
37	14,781.20
38	15,224.65
39	15,681.40
40	16,151.85

Following the Insured's death, the Monthly Benefit amount will increase by 3% on each policy anniversary during the Benefit Period.

POLICY SPECIFICATIONS

TABLE OF INITIAL MONTHLY BENEFITS

{Note: Sample is for 3% Increasing Monthly Benefit}
 INSURED: [LELAND STANFORD]
 (CONTINUED)

IF INSURED'S DATE OF DEATH IS IN POLICY YEAR	INITIAL MONTHLY BENEFIT WILL BE
41	\$16,636.40
42	17,135.50
43	17,649.55
44	18,179.05
45	18,724.40
46	19,286.15
47	19,864.70
48	20,460.65
49	21,074.50
50	21,706.70
51	22,357.90
52	23,028.65
53	23,719.50
54	24,431.10
55	25,164.05
56	25,918.95
57	26,696.55
58	27,497.40
59	28,322.35
60	29,172.00]

Following the Insured's death, the Monthly Benefit amount will increase by 3% on each policy anniversary during the Benefit Period.]

DEFINITIONS

In this section, we define certain terms used throughout this policy. Other terms may be defined in other parts of the policy. Defined terms are usually capitalized to show emphasis.

Administrative Office – is the office that administers your policy. The address of the Administrative Office at the time you applied for this policy is shown in the heading of the Application. If the address changes, we will send you written notice of the new address.

Age – means the age as of the Insured's birthday nearest to the Policy Date, increased by the number of complete policy years elapsed.

Application – consists of the application for this policy, including any Certificate of Health, amendments, or endorsements, and any application for reinstatement or increase in benefits.

Benefit Period – is the period of time during which Monthly Benefits are payable under this policy if the Insured dies during the Coverage Period. It begins if the Insured dies prior to the Expiration date. The Benefit Period will end on the Level Premium Period End Date or, if later, when the 60th Monthly Benefit payment has been made.

Code – is the U.S. Internal Revenue Code of 1986, as amended, and the rules and regulations issued thereunder.

Coverage Period – is the period of time, while this policy is In Force, during which a Death Benefit is payable under this policy if the Insured dies during such period. The Coverage Period began as of the Policy Date. The Coverage Period will end on the Expiration date shown on the Policy Specifications, or if earlier, when the policy ceases to be In Force.

Evidence of Insurability – is information, including medical information, satisfactory to us that is used to determine insurability and the Insured's Risk Class.

Insured – is the person insured under this policy, as shown in the Policy Specifications.

Insured's Date of Death – is the date the Insured dies. However, if the Insured dies on the 29th, 30th, or 31st day of a month, then the Insured's Date of Death will be the 28th day of such month.

In Force – means a policy is in effect and provides death benefit coverage on the Insured.

Level Premium Period – is the period of time during which the premium for this policy is unchanged, other than a change due to the termination of a temporary higher premium due to a substandard rating, if any (substandard rating is indicated by use of "rated" as part of Risk Class). The Level Premium Period begins as of the Policy Date and ends on the Level Premium Period End Date shown in the Policy Specifications. The premium increases on the Level Premium Period End Date and on each policy anniversary thereafter. Annual premiums for all policy years are shown in the Policy Specifications.

Monthly Benefit – is payable monthly for the duration of the Benefit Period if the Insured dies during the Coverage Period and depends on the policy year of the Insured's death, as shown in the Policy Specifications.

Owner, you, or your – refers to the Owner of this policy.

Policy Date – is shown in the Policy Specifications. Policy months, years, and anniversaries are measured from this date.

Policy Specifications – is a section of the policy that shows information specific to your policy.

Risk Class – is used in determining policy premiums and is determined by us during the underwriting process. It depends on the Insured's gender, health, tobacco use, and other factors. The Risk Class is shown in the Policy Specifications. Risk Class may also be referred to as Risk Classification.

We, our, ours, and us – refer to Pacific Life Insurance Company.

Written Request – is your signed request in writing, or on a form we provide, and received by us at our Administrative Office, containing information we need to act on the request.

DEATH BENEFIT

When the Policy is In Force – This policy is In Force as of the Policy Date, subject to your acceptance of the delivered policy and payment of the initial premium. The policy remains In Force until terminated as provided in the Termination provision as long as premiums are paid when due or within the Grace Period.

Death Benefit – This policy provides a Death Benefit payable if the Insured dies during the Coverage Period. The Death Benefit is payable in the form of a Monthly Benefit for the duration of the Benefit Period and may be subject to adjustment as provided in the Misstatement provision or elsewhere in the policy. Payment of the first Monthly Benefit is due on the same day of the month as that of the Policy Date, next following the Insured's Date of Death. Monthly Benefit payments will be payable each calendar month thereafter for the duration of the Benefit Period on the same day of the month as that of the first Monthly Benefit. The Death Benefit is not available as a lump sum amount.

Death Benefit Proceeds – The Death Benefit Proceeds ("Proceeds") are the actual amounts payable if the Insured dies during the Coverage Period. The Proceeds are equal to the Death Benefit plus the pro-rata portion of any premium paid beyond the end of the policy month of death, less the amount of any premiums that are due but not yet paid at the time of death. These adjustments to the Death Benefit will be reflected in the first Monthly Benefit payment, and subsequent Monthly Benefit payments if necessary.

We will begin to pay the Proceeds after we receive, at our Administrative Office:

- Due proof of the Insured's death, consisting of a certified copy of the death certificate for the Insured or other lawful evidence providing equivalent information
- Proof of the claimant's legal interest in the proceeds
- Sufficient evidence that any legal impediments to payment of Proceeds that depend on parties other than us have been resolved. Legal impediments to payment include, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; (c) submission of information required to satisfy state and federal reporting requirements; and (d) conflicting claims

Proceeds paid are subject to the conditions and adjustments defined in other policy provisions, such as General Provisions. We will pay interest on any Proceeds not paid when due at a rate required by applicable law.

PREMIUMS

Premium Payments – This policy will not be In Force until the initial premium is paid. The initial premium is payable either at our Administrative Office or to our authorized representative. Subsequent premiums are payable only at our Administrative Office. At your request, a premium receipt signed by one of our officers will be given to you. We will notify you at your last known address if there is a change in this mailing address. Any premium paid after the initial premium will be considered 'received by us' when it is actually received at our Administrative Office. Except for the initial premium, Pacific Life bears no responsibility for any premium unless the premium is received by us. Premiums are level during the Level Premium Period. Thereafter, premiums increase annually.

Guaranteed Premiums – There is a table of Premiums shown in the Policy Specifications. Those premiums are guaranteed and cannot be changed by us.

POLICY LAPSE AND REINSTATEMENT

Grace Period and Lapse – After the first premium, there is a Grace Period of 31 days from the premium due date for you to pay each premium. The policy will continue In Force during the Grace Period. If any premium is not paid by the end of its Grace Period, this policy will lapse. The date of lapse will be the due date of the unpaid premium. Upon lapse, the policy will terminate with no value and no coverage will be In Force.

Reinstatement – If this policy terminates due to lapse, it may be reinstated during the Coverage Period and within five years after the end of the Grace Period. To reinstate this policy you must provide us with the following requirements:

- Your written Application
- Evidence of Insurability satisfactory to us
- Payment of all past due premiums, with interest at an effective annual rate of 6% from their due dates to the reinstatement effective date

The reinstatement effective date will be the beginning of the policy month that follows our receipt of the above requirements and our approval of your Application.

TERMINATION

This policy will terminate and, except for the limited right to reinstate the policy, all rights of the owner will end upon the earliest of the following events:

- The Expiration date, if the Insured is alive on the Expiration date
- The end of the Benefit Period, if the Insured dies during the Coverage Period
- Lapse of this policy, as provided in the Grace Period and Lapse provision
- Successful contest of this policy as described in the Incontestability provision
- Our receipt of your Written Request to terminate the policy

Upon termination we will refund to you the pro-rata portion of any premium you have paid that applies to a period beyond the end of the policy month in which the policy terminates

OWNER AND BENEFICIARY

Owner – The Owner of this policy is as shown in the Policy Specifications or in a later Written Request. If you change the Owner, the change is effective on the date the Written Request is signed, subject to our receipt of it. If there are two or more Owners, they will own this contract as joint tenants with right of survivorship, unless otherwise provided by Written Request. While this policy is In Force, the Owner will have the rights described herein. After the Insured's death, the Owner will have no rights under the policy.

Beneficiary – A Beneficiary is a person named by you in the Application to receive the Death Benefit proceeds. You may name one or more Beneficiaries. If you name more than one Beneficiary, they will share the Death Benefit proceeds equally or as you may otherwise specify by Written Request. The interest of a Beneficiary who does not outlive the Insured will be divided pro rata among the surviving Beneficiaries. In the event of a simultaneous death of the Insured and a Beneficiary such that it cannot be determined who died first, it will be assumed, unless proof to the contrary is provided, that the Beneficiary died last. You may designate any Beneficiary as a Permanent Beneficiary whose rights under

the policy cannot be changed without his or her written consent. To the extent allowed by law, policy benefits will not be subject to the claims of any creditor of any Beneficiary.

Contingent Beneficiary – You may name a Contingent Beneficiary, who becomes the Beneficiary if no other Beneficiary survives to receive the Monthly Benefits.

Change of Beneficiary – Except for a Permanent Beneficiary, you may change any Beneficiary by Written Request on a form provided by us while the policy is In Force. The change will take place as of the date the request is signed. Any rights created by the change will be subject to any payments made or actions taken by us before we have received the Written Request. .

Assignment – You may assign this policy by Written Request. An assignment will take place only when recorded at our Administrative Office. When recorded, the assignment will take effect as of the date the Written Request was signed. Any rights created by the assignment will be subject to any payments made or actions taken by us before the change is recorded. We will not be responsible for the validity of any assignment. A Beneficiary may not, at or after the Insured's death, assign, transfer or encumber any benefit payable.

GENERAL PROVISIONS

Entire Contract – This policy is a contract between you and us. This policy, the attached copy of the initial Application, including any amendments and endorsements to the Application, any applications for reinstatement, any endorsements, benefits, or riders, and all additional policy information sections added to this policy are the entire contract. Only our president, chief executive officer or secretary is authorized to change this contract or extend the time for paying premiums. Any such change must be in writing.

All statements in the Application shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement to contest this policy or defend a claim on grounds of misrepresentation unless the statement is in an Application.

Incontestability – We will not contest this policy unless there was a material misrepresentation in the Application. If we determine that the Application contains a material misrepresentation, we will rescind the policy and return to you the premiums paid. No Death Benefit will be paid. Unless you fail to pay required premiums, this policy cannot be contested, except as provided below, after it has been in force for two years during the Insured's lifetime.

If this policy lapses and is later reinstated, we will not contest the reinstated policy unless there was a material misrepresentation in the Application required for reinstatement. If we determine that such Application contains a material misrepresentation, we will rescind the reinstated policy as of the reinstatement date and return to you the premiums paid after the reinstatement date. No Death Benefit will be paid. We will not contest the reinstated policy after it has been in force for two years following such reinstatement during the Insured's lifetime.

Conversion – This policy cannot be converted to another policy.

Non-Participating – This policy will not share in any of our surplus earnings.

Suicide Exclusion – If the Insured dies by suicide, while sane or insane, within two years of the Policy Date, the Death Benefit Proceeds will be limited to an amount equal to the sum of the premiums paid.

Misstatement – If we discover that the Insured's sex or birth date was misstated in the application, we will adjust all policy benefits at such time. The adjusted benefit amounts, end dates for benefits, and other features will be those that the premiums paid would have purchased using the correct sex and birth date. The adjustment will occur whether the misstatement is discovered before or after the death of the Insured.

Compliance – We reserve the right to make any change to the provisions of this policy to comply with, or to give you the benefit of, any federal or state statute, rule, or regulation, including but not limited to requirements for life insurance contracts under the Code. We will provide you with a copy of any such change, and file such a change with the insurance supervisory official of the state in which this policy is delivered. You have the right to refuse any such change.

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PACIFIC LIFE

Pacific Life Insurance Company • 45 Enterprise Drive • Aliso Viejo, CA 92656

MONTHLY BENEFIT TERM LIFE INSURANCE

- **Death Benefit Payable If the Insured Dies During the Coverage Period**
- **Coverage Period to Age 95**
- **Death Benefit Payable as a Monthly Benefit for the Duration of the Benefit Period**
- **Premiums Payable as Provided Herein**
- **Non-Participating**
- **Non-Convertible**

ACCELERATED LIVING BENEFIT RIDER

This rider is attached to and made part of your policy.

Issue Date: _____ Policy Number: _____

POLICY DEATH BENEFITS WILL BE REDUCED IF A LIVING BENEFIT IS PAID. ANY LIVING BENEFIT RECEIVED UNDER THIS RIDER MAY BE TAXABLE. YOU SHOULD CONSULT YOUR TAX ADVISOR PRIOR TO REQUESTING THIS BENEFIT. ANY LIVING BENEFIT RECEIVED UNDER THIS RIDER MAY AFFECT WHETHER YOU QUALIFY FOR MEDICAID, MEDICARE, SOCIAL SECURITY OR OTHER GOVERNMENT BENEFITS. A LIVING BENEFIT IS NOT INTENDED AS HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT INTENDED OR DESIGNED TO ELIMINATE THE NEED FOR SUCH COVERAGE.

This rider is not meant to cause involuntary access to proceeds payable to the beneficiary on the death of the Insured. Therefore, this benefit is not available if either the Owner or Insured:

- a) is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- b) is required by a government agency to use this benefit in order to apply for, obtain or keep a government benefit or entitlement.

Rider Benefit - The Owner may elect to receive, while the Insured is living, a portion of the Death Benefit of the policy. We will pay a Living Benefit if the Insured has been diagnosed with a terminal illness. By "terminal illness", we mean an illness with a life expectancy of 12 months or less.

Charge for This Benefit - There may be a processing charge not to exceed \$150 deducted from the Living Benefit upon exercise of this rider.

Definitions

Requested Percentage is the percentage of the policy proceeds you request. The Requested Percentage cannot exceed 50%.

Living Benefit - is the actual dollar amount of benefit you will receive under this rider. The Living Benefit will be determined as of the date we approve your Written Request to exercise the rider. Your Living Benefit will be calculated as the commuted value, using 5% annual interest, of the Requested Percentage of the Monthly Benefits otherwise payable under the policy if the Insured were to die 12 months after the exercise date of this rider, and will be subject to the following adjustments:

- 1) We will reduce the Living Benefit by the amount of any premiums due and unpaid if the policy has entered the Grace Period at the time we approve your request.
- 2) We will reduce the Living Benefit by the processing charge (see above).

We will refund the amounts discussed in 2) above should the death of the Insured occur within 30 days after our payment of the Living Benefit to you.

The Living Benefit will be paid as a lump sum. The Living Benefit is subject to a minimum of \$500 and a maximum of \$250,000. We place no restrictions on how you use any Living Benefit that may be paid under this rider. We will pay the Living Benefit only once per Insured, even if such person may be insured with us under more than one policy.

Impact on the Policy - After a Living Benefit is made, the policy and all riders will remain in force subject to the following adjustments. The Monthly Benefit of the policy and any required premium payments will be

reduced by the Requested Percentage. A statement demonstrating how the Living Benefit impacts policy values will be sent with the Living Benefit.

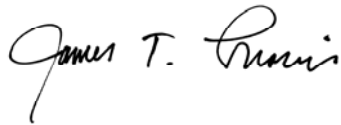
Eligibility - The following conditions must be met before any Living Benefit is made:

- The policy must be in force on the date we approved the Living Benefit.
- The Expiration Date of your policy must be at least 2 years from your Written Request.
- We must receive written proof that the life expectancy of the Insured is 12 months or less from the date of the Written Request. Proof will include the certification by a licensed physician. Such person may not be yourself or a member of your family. Such proof should include clinical, radiological or laboratory evidence of the condition. We reserve the right to obtain a second medical opinion from a physician of our choice at our expense. In the case of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion, at our expense, provided by a physician who is mutually acceptable to you and to us.
- The Owner or legal guardian must apply in writing for this benefit on a form supplied by us.
- Written consent from any irrevocable beneficiary and any assignee is required.

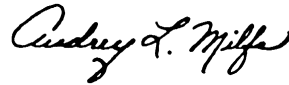
Effective date - This rider is effective on the issue date specified and will end at the earliest of the following:

- When you make a Written Request to end the rider
- When the policy ends
- When a Living Benefit is paid

Signed for Pacific Life Insurance Company,



Chairman, President and Chief Executive Officer



Secretary

PACIFIC LIFE INSURANCE COMPANY

[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

**PACIFIC LIFE****APPLICATION FOR TERM LIFE INSURANCE****PROPOSED INSURED**

1A. Name: First		MI	Last		B. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
C. Residence Address: Street		City		State	Zip Code	
E. Date of Birth (mm/dd/yyyy)		F. Place of Birth (State/Country)		G. Soc. Sec. #	H. Driver's License # & State	
						I. Telephone # (include area code)
2A. Employer's Name				B. Occupation		
C. Employee's Work Address: Street		City		State	Zip Code	
						D. How Long yr mo
3. Annual earned income from occupation \$		4. Annual unearned income (State sources in Remarks) \$		5. Net Worth <input type="checkbox"/> Individual <input type="checkbox"/> Joint \$		
6. Is the Proposed Insured married or in a legally recognized civil union or domestic partnership? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list amount of life insurance in force on your spouse/partner \$						
7A. Proposed Insured is a: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> U.S. Permanent Resident <input type="checkbox"/> Foreign National (Complete 7B through D)						
B. If Foreign National, provide Country		C. Visa Type			D. How long in this country?	

PRIMARY POLICYOWNER (If multiple Policyowners, they will own the policy as joint tenants with rights of survivorship unless otherwise stated.)

1. Policyowner is: <input type="checkbox"/> Same as insured (Do not complete #2) <input type="checkbox"/> Individual <input type="checkbox"/> Trust (Complete Trust Information form) <input type="checkbox"/> Partnership <input type="checkbox"/> Business, Corporation, or Employer Controlled Trust (Complete Insured's Consent & Employer Acknowledgment form)		
2A. Name		B. Relationship to Proposed Insured
C. Address: Street		City
		State
		Zip Code
D. Date of Trust (If applicable)		E. Soc. Sec. # / Tax ID #
		F. Telephone # (include area code)

BENEFICIARY (If percentages are left blank, all named Primary Beneficiaries will share equally. If more space is needed, use Remarks.)

Primary	1A. Name	B. % Share	C. Date of Birth (mm/dd/yyyy)
	D. Relationship to Proposed Insured	E. Soc. Sec. # / Tax ID #	F. Date of Trust (mm/dd/yyyy)
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	2A. Name	B. % Share	C. Date of Birth (mm/dd/yyyy)
	D. Relationship to Proposed Insured	E. Soc. Sec. # / Tax ID #	F. Date of Trust (mm/dd/yyyy)

POLICY INFORMATION

1. Product Name		2. Face Amount (Not Applicable for Pacific Income Term) \$	
3. Pacific Income Term Only: Initial Monthly Benefit Amount \$		<input type="checkbox"/> Level <input type="checkbox"/> Increasing (3% annually)	
4. Additional Benefits: [<input type="checkbox"/> Accelerated Living Benefit Rider (Complete disclosure form) <input type="checkbox"/> Premium Waiver Rider]			
5. Policy Date: A current policy date will be used unless you select one of the following. <input type="checkbox"/> Date to Save Age <input type="checkbox"/> Specific Date (mm/dd/yyyy) Indicate a date, excluding 29th, 30th, and 31st By requesting a backdated policy, all parties understand that premiums will be applied as if coverage began on the Policy Date.			
6. Premium Frequency: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Bank Draft (Complete Auth. for EFT form)			
7. Amount Paid With This Application: (Do not submit money unless the Temporary Insurance Agreement (TIA) is completed) Is an initial premium submitted with this application? <input type="checkbox"/> No <input type="checkbox"/> Yes Amount \$ If Yes, by signing this application, all parties understand, accept, and agree to the terms of the TIA.			



OTHER LIFE INSURANCE: IN FORCE, PENDING, AND REPLACEMENT INFORMATION (Certain states require replacement forms for in force policies even if a replacement is not intended.)

1. Is there any existing life insurance or annuity on the Proposed Insured?
☐ Yes ☐ No (If Yes, complete any applicable state replacement notice and submit with the application.)
2. Will the Pacific Life policy applied for replace, cause a change in, or involve a cash withdrawal or loan from or lapse of any life insurance policy or annuity on the Proposed Insured's life?
☐ Yes ☐ No (If Yes, complete the applicable state replacement forms and submit with the application.)
3. Complete the chart below for any **existing** life insurance or annuity:

Policy/ Contract #	Company	Face Amount	Issue Year	Check All Applicable Boxes						
				Replace	Life	Annuity	Individual	Group	Business	Personal

4. Do you have any application currently **pending**, or do you **plan to apply** for any new life insurance or annuity with any other company?
☐ Yes (Complete chart below) ☐ No

Company	Face Amount	Purpose

5. What is the ultimate total line of coverage (including this policy, other in force coverage, pending or planned policies, and subtracting policies to be replaced)? \$ _____

TOBACCO USE INFORMATION

1. Within the last 5 years, has the Proposed Insured used or smoked tobacco and/or any other product containing nicotine in any quantity?
☐ No ☐ Yes (If Yes, check all that apply and indicate date (mm/yyyy) product was last used.)

Type of Product	Date Last Used	Type of Product	Date Last Used	Type of Product	Date Last Used
<input type="checkbox"/> Cigarettes		<input type="checkbox"/> Pipe		<input type="checkbox"/> Nicotine Patch/Gum	
<input type="checkbox"/> Cigars		<input type="checkbox"/> Chewing Tobacco		<input type="checkbox"/> Other _____	

GENERAL INFORMATION (To be completed by Proposed Insured. Provide details in Remarks.)

1. Within the next 2 years do you plan to fly, or within the last 2 years have you flown, as a pilot, student pilot, or crewmember? (If Yes, complete the Aviation Questionnaire)
2. Within the next 2 years do you plan to participate in, or within the last 2 years have you participated in, parachute jumping, scuba diving, auto/motorboat/motorcycle racing, hang gliding, or mountain climbing? (If Yes, complete the Avocation Questionnaire)
3. Do you plan or expect to travel or reside outside the USA? (If Yes, complete the Foreign Residence & Travel Questionnaire)
4. Have you applied for any other life insurance within the last 6 months?
5. Have you ever had life insurance declined, rated, modified, cancelled, or not renewed?
6. Have you been convicted of a felony within the past 5 years?
7. Have you had a driver's license restricted or revoked or been convicted of 3 or more moving violations within the past 5 years?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

REMARKS (Use additional sheets of paper, if necessary.)

DATE STAMP (For Internal Use Only)

APPLICANT/OWNER REPRESENTATION OF INSURABLE INTEREST

As the Applicant and/or Policyowner, I represent that the Policyowner and Beneficiary have an insurable interest in the life of the Proposed Insured. (Applicable except where the Proposed Insured is both Applicant and Policyowner.)

DECLARATIONS OF ALL SIGNING PARTIES

The answers provided in this application are true and complete to the best of my knowledge and belief. I understand and agree that:

1. (NOT APPLICABLE IN WEST VIRGINIA) Acceptance of a life insurance policy will be ratification of any administrative change with respect to such policy made by Pacific Life as indicated under the title Endorsement, where permitted by state law. All other changes made to the application or policy by Pacific Life will be indicated on an Amendment to Application form that must be signed by all applicable parties, prior to or at the time of delivery of this policy.
2. If I am an active duty member of the United States Armed Forces (including active duty military reserve personnel), I confirm that this application was not solicited and/or signed on a military base or installation, and I have received from the Insurance Professional, whose name appears in the Insurance Professional's Certification section, the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.
3. Except as provided in the terms or conditions of any Temporary Insurance Agreement (TIA) that I may have received in connection with this application, coverage will take effect when the policy is delivered and the entire first premium is paid only if at that time the Proposed Insured is alive, and all answers in this application that are material to the risk are still true and complete.
4. If I have given money with the application and received a TIA and if the coverage amount of the application exceeds the TIA coverage limits, I understand that if the Proposed Insured dies before a policy is delivered, the death benefit will be limited to the TIA coverage limit.
5. I must inform the Insurance Professional or Pacific Life Insurance Company (PL) in writing of any changes in the health of the Proposed Insured or if any of the statements or answers on this application change prior to delivery of the policy.
6. My statements and answers in this application must continue to be true as of the date I receive the policy.
7. No Insurance Professional is authorized to make or change contracts or insurance policies on the behalf of Pacific Life and no Insurance Professional may alter the terms of this application, the TIA, or the policy, nor does the Insurance Professional have the authority to waive any of Pacific Life's rights or requirements.
8. No representation is made that, based on information provided in the application, a particular premium rate, risk category or class will be offered to me. I will review my policy and ask the Insurance Professional or the Company about the specific premium and risk class referenced in my policy.
9. The policy as applied for in this application will meet my insurance needs and financial objectives based in part upon my age, income, net worth, tax and family status, and any existing insurance policies I own.
10. (APPLICABLE ONLY IF THE EMPLOYER OR AN EMPLOYER-CONTROLLED TRUST IS TO BE THE OWNER OF THIS POLICY If insurance is being applied for on the life of any non-exempt employee, then such insurance is not prohibited by applicable state law.

SIGNATURES

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in Oregon.)

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and make the statements that may be shown. You further represent that all requirements of those entities, including the use of corporate seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust), have been met.

If Policyowner is under age 16, a signature of parent/guardian is required in place of the minor's signature.

SIGNED BY APPLICANT IN:

City	State
------	-------

APPLICANT SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN
HERE

X

Proposed Insured's Signature

SIGN
HERE

X

Policyowner's Signature, if other than Proposed Insured, and include Title, if Corporation, Trust, or Business Entity

SIGN
HERE

X

Applicant's Signature, if other than Proposed Insured and/or Policyowner, and include Title, if Corporation, Trust or Business Entity

SIGN
HERE

X

Additional Policyowner's Signature & Title, if applicable

THE APPLICANT IS THE PARTY THAT APPLIES FOR THE POLICY.

INSURANCE PROFESSIONAL'S CERTIFICATION

I certify that I have truly and accurately recorded the information supplied in the application and any supplements, if required.

SIGN
HERE

X

Soliciting Insurance Professional's Signature

Soliciting Insurance Professional's Name: First MI Last (print)

PACIFIC LIFE INSURANCE COMPANY

[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

**PACIFIC LIFE****TEMPORARY INSURANCE AGREEMENT (TIA) – LIFE**

Proposed Insured's Name: First MI Last	Date of Birth (mm/dd/yyyy)
---	-----------------------------------

This TIA provides a limited amount of life insurance coverage, for a limited period of time, subject to the Terms and Conditions shown below.

Advance payment in the amount of \$ _____ (checks must be made payable to "Pacific Life Insurance Company") is made in connection with either a request for determination of probable underwriting class or an application for life insurance (each referred to below as "Application") for proposed insured.

HEALTH QUESTIONS

Has any Proposed Insured:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Within the past 90 days been admitted to a hospital or other medical facility, been advised to be admitted, or had surgery performed or recommended? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 5 years been diagnosed or treated by a member of the medical profession for heart trouble, stroke, cancer or for Acquired Immune Deficiency (AIDS) or AIDS Related Complex (ARC) or other immune deficiency disorders? | <input type="checkbox"/> | <input type="checkbox"/> |

If any of the above questions are answered YES or LEFT BLANK, or if any Proposed Insured is under 15 days of age or over age 70 (nearest birthday) on the date of this TIA, no representative of Pacific Life Insurance Company (PL) is authorized to accept money, and NO COVERAGE will take effect under this TIA.

TERMS AND CONDITIONS

AMOUNT OF COVERAGE - \$1,000,000* OVERALL MAXIMUM FOR ALL TIAs (\$1,500,000 OVERALL FOR SECOND-TO-DIE LIFE INSURANCE APPLICATIONS)	If money has been accepted by PL as advance payment in connection with a Application and if any Proposed Insured dies (or for Second-to-Die life insurance Applications, if both Proposed Insured's die) while this TIA is in effect, PL will pay the designated beneficiary the lesser of (a) the amount of death benefits, if any, which would be payable under the policy and its riders if issued as shown in the Application, excluding any accidental death benefits, or (b) \$1,000,000* (\$1,500,000 for Second-to-Die life insurance Application). PL's aggregate liability under all TIAs in effect shall be subject to this limitation. *For Monthly Benefit Term Life Insurance only, coverage under this TIA is limited to the lesser of the Monthly Benefit applied for or a Monthly Benefit of \$5,000.
DATE COVERAGE BEGINS	Temporary life insurance under this TIA will begin on the date of this TIA, but only if an Application has been completed and signed on the same date.
DATE COVERAGE TERMINATES (90 DAY MAXIMUM)	Temporary life insurance under this TIA will terminate automatically on the earliest of: a. 90 days from the date of this TIA; b. the date any policy is offered in connection with a Application; or c. five days after the date PL mails notice of termination of coverage and refunds the advance payment. PL reserves the right to terminate this TIA under any of the following circumstances: a. 30 days have elapsed since the date of this TIA, and PL has not received in its Home Office the report of the medical examination, if such examination is required by PL's underwriting rules; b. PL has determined that any Proposed Insured is not insurable as a standard risk at the time of the Application or the medical examination, if later; or c. there are any errors or omissions on the current Application.
LIMITATIONS	This TIA does not provide benefits for disability. Fraud or material misrepresentation in the Application or in the answers to the Health Questions of this TIA invalidates this TIA, and PL's only liability is to refund any premium payment made. If any Proposed Insured dies by suicide, PL's liability under this TIA is limited to a refund of the payment made. There is no coverage under this TIA if the check submitted as payment is not honored by the bank on first presentation. No one is authorized to waive or modify any of the provisions of this TIA.

I HAVE RECEIVED A COPY OF AND HAVE READ THIS TIA AND DECLARE THAT THE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND AND AGREE TO ALL ITS TERMS AND CONDITIONS.

Dated _____
Month Day Year

X _____
Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

X _____
Signature of Insurance Professional

X _____
Signature of additional Proposed Insured (if applicable)

NOTICE TO APPLICANT: Please retain your copy of this TIA. The original will be retained by PL. If you do not hear from us regarding the Application within 100 days from the date of this TIA, notify us at [P.O. Box 2030, Omaha, NE 68103-2030, Attention: New Business Services].

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Not applicable in Oregon.)

INSURANCE PROFESSIONAL: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES



PACIFIC LIFE INSURANCE COMPANY

[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

**PACIFIC LIFE****FOREIGN RESIDENCE AND TRAVEL QUESTIONNAIRE – PAST AND FUTURE****PROPOSED INSURED**

Name: First	MI	Last	Policy Number
-------------	----	------	---------------

FOREIGN RESIDENCE (Complete this section if your primary residence is outside of the United States, Canada, Guam, or Puerto Rico.)

Primary Residence: City	Country	How Long? yr mo
Secondary Residence: City	Country	How Long? yr mo

If you expect to do any additional traveling while residing abroad complete the Future Travel section.

Past Travel (Complete this section for all travel outside the United States (or your country of residence) for the last 3 years. Use separate sheet if

	Trip 1		Trip 2		Trip 3	
Country Name						
City(ies) or Region Expected to Visit						
Length of Stay	___ Days ___ Weeks ___ Months		___ Days ___ Weeks ___ Months		___ Days ___ Weeks ___ Months	
Dates	From	To	From	To	From	To
Purpose of Trip:	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:	

Continued...

Future Travel (Complete this section for all intended travel outside the United States (or your country of residence) for the next 3 years. Use a separate sheet if necessary.)					
	Trip A		Trip B		Trip C
Country Name					
City(ies) or Region Expected to Visit					
Number of Trips					
Length of Stay	____ Days ____ Weeks ____ Months		____ Days ____ Weeks ____ Months		____ Days ____ Weeks ____ Months
Expected Dates	From	To	From	To	From To
Accommodations:	<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____		<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____		<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____
Purpose of Trip:	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

Date (mm/dd/yyyy)



Page 2 of 2

<i>SERFF Tracking Number:</i>	<i>PALD-126375439</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pacific Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44173</i>
<i>Company Tracking Number:</i>	<i>P10IRT</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>P10IRT</i>		
<i>Project Name/Number:</i>	<i>P10IRT/P10IRT</i>		

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	
Comments:		
Attachments:		
AR Reg 19 Cert of Compliance.pdf		
AR1GuarAssocNote.pdf		
Readability Certification (A09TPF).pdf		

	Item Status:	Status Date:
Bypassed - Item:	Application	
Bypass Reason:	Application to be used with the filed policy is also being filed for approval.	
Comments:		

	Item Status:	Status Date:
Satisfied - Item:	Application Package	
Comments:		
These forms are a part of the "Application package"; that is, they are always included with the application when it is being completed by the Insurance Professional and the applicant. They are not filed for approval, however, because they do not become a part of the contract. I have included them here since they include information that you may want to reference, including the Producer's replacement question, the applicant's authorization form and the disclosure document discussing MIB, Inc. and the sharing of information.		
Attachments:		
A09AUT1.pdf		
A10DIS.pdf		
A10PRT.pdf		

	Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	

SERFF Tracking Number:	PALD-126375439	State:	Arkansas
Filing Company:	Pacific Life Insurance Company	State Tracking Number:	44173
Company Tracking Number:	P10IRT		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life
Product Name:	P10IRT		
Project Name/Number:	P10IRT/P10IRT		

Comments:

Attachments:

Statement of VariabilityIRT.pdf

Statement of Variability App.pdf

Item Status:

Status

Date:

Satisfied - Item: Disclosure Statements

Comments:

Attachment:

N03ALBD1.pdf

PACIFIC LIFE INSURANCE COMPANY
45 Enterprise Drive · Aliso Viejo · California · 92656

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

RE: P10IRT

I hereby certify that to the best of my knowledge and belief, the above forms and their submission comply with Regulation 19, as well as the other laws and regulations of the State of Arkansas.

Signed for the Company at Aliso Viejo, California on November 23, 2009

SIGNATURE

Thomas S. Beadleston

NAME

Vice President

TITLE

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Disability Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Disability Insurance Guaranty Association
c/o The Liquidation Division
1200 West Third Street (Third & Cross)
Little Rock, Arkansas 72201-1904

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety net is called the Arkansas Life and Disability Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or disability insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$100,000 in health insurance benefits, \$100,000 in present value of annuity benefits, or \$100,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

READABILITY CERTIFICATION

Form Filing for: **Pacific Life Insurance Company**

Policy Form Number(s): P10IRT
R10ALB
A10TRM
A10TIA
A10TPF

Form Name(s): Monthly Benefit Term Life Insurance
Accelerated Living Benefit Rider
Application for Term Life Insurance
Temporary Insurance Agreement
Foreign Residence/Past and Future Foreign Travel Questionnaire

Flesch Score(s): 50.7
53.1
50.2
51.8
51.2

(Flesch test was made for entire form, not for selected samples.)

Test type: 10 point

I certify that in my judgment this filing is:

- READABLE (simple sentence structure – shortness of sentences – use of common words – avoidance of legal and technical terms to greatest possible extent and defining of those terms which cannot be avoided – minimum of cross-references).
- LEGIBLE (ample type size for text with contrasting type for headings and subheadings – ample space between lines – ample white space in margins and between section – ample ink-to-paper contrast).
- IN LOGICAL ORDER AND FORMAT (table of contents or index included – sections and subsections self-contained and arranged in logical flow – extensive use of headings and subheadings to facilitate location of particular items – outline form used where desirable for clarity).

I believe this filing:

- Meets or exceeds the requirements of the policy readability legislation already enacted in numerous states; and
- Meets or exceeds the requirements of the NAIC Model Bill on language simplification.

Signed for the Company at Newport Beach, California on

November 18, 2009



SIGNATURE

THOMAS S. BEADLESTON

NAME

VICE PRESIDENT

TITLE

PACIFIC LIFE INSURANCE COMPANY

[Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

**PACIFIC LIFE****AUTHORIZATION TO OBTAIN INFORMATION**

This authorization complies with HIPAA Privacy Rules

PROPOSED INSURED'S INFORMATION

Proposed Insured's Name: First	MI	Last	Date of Birth (mm/dd/yyyy)	Place of Birth (state/country)
Proposed Additional Insured's Name: First	MI	Last (if applicable)	Date of Birth (mm/dd/yyyy)	Place of Birth (state/country)

I authorize any physician, health care professional, medical practitioner, other health care provider, hospital, clinic, laboratory, pharmacy, medical facility, other medical or medically related facility, insurance company, health plan, MIB, Inc., consumer reporting agency, state motor vehicle agency, or employer to release to **Pacific Life Insurance Company ("PL")** its subsidiaries, reinsurers, employees and representatives, any information they may have in their possession or under their control as to the diagnosis, treatment, prognosis of any physical or mental condition, human immunodeficiency virus (HIV) infection, sexually transmitted diseases, treatment of mental illness, and the use of tobacco, and any non-medical information, including finances, avocations, occupation, foreign travel, and driving record for me and any minor children who are to be insured. Although Federal Regulation protects information related to drug or alcohol abuse from disclosure, I give permission to collect this information. This authorization is not affected or limited by any prior agreements I may have made with any of the above persons or entities to restrict the release of such information, and I instruct them to release and disclose all such information without restriction.

I understand that the reason for releasing such information under this authorization is to determine eligibility for insurance and that such information will not be released to any person or organization except a reinsurer, MIB, Inc., and other persons or organizations performing business or legal services in connection with my application, or as may be otherwise required by law, or as I may further authorize. I understand that I may revoke this authorization at any time by sending a written revocation request to Pacific Life Insurance Company at: [P. O. Box 2030, Omaha, NE 68103-2030]. Such a revocation will not affect any action taken or information released prior to the revocation, and will not affect any legal right Pacific Life has to contest an insurance policy/certificate, or to contest a claim under an insurance policy/certificate. I understand that if I revoke this authorization, Pacific Life may not be able to process my application, and may not be able to make any benefit payments due under any existing policy, certificate, or other binding agreement.

This authorization shall remain in force for 24 months after the date of my signature below, and a copy of this authorization is as valid as the original. I understand that once any such health-related information is released pursuant to this authorization, that information may be redisclosed and will no longer be covered or protected by the HIPAA rules governing privacy and confidentiality of health information.

I acknowledge that I have received the disclosure notice and a copy of this authorization.

SIGNATURES

Signed and Dated by the Insured(s) in: _____
City State Date (mm/dd/yyyy)

**X**

Proposed Insured's Signature (or parent/guardian if under age 16)

**X**

Proposed Additional Insured's Signature (or parent/guardian if under age 16)



PACIFIC LIFE INSURANCE COMPANY

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DISCLOSURE NOTICE

DETACH AND LEAVE WITH PROPOSED INSURED(S)

In this disclosure, “we”, “us”, “our”, and “PL” refer to Pacific Life Insurance Company, its affiliates, and its subsidiaries. This brief description of our underwriting process is designed to help you to understand how an application for life insurance is handled, the types and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right, or that of your authorized representative, to learn the nature and substance of that information upon written request. The purpose of the underwriting process is to make sure you qualify for life insurance under our rules, and assuming you do, establish the proper premium charge for that insurance. The goal of the underwriting process is to have the cost of insurance distributed equitably among all policyowners, so that each individual pays his or her fair share. To determine your insurability, we must consider such factors as your medical history, physical condition, occupation, and hazardous avocations. We get this information from various sources.

Application and Medical Records – Your application, including the medical history, is the primary source of information in the evaluation process. In addition, we may ask you to take a physical examination or other special test such as an electrocardiogram. We may also ask for a report from your doctor or hospital, another insurance company, or MIB, Inc. (“MIB”, see below). When we do so, we will use the Authorization To Obtain Information that you signed. The purpose of MIB is to protect member companies, their policyowners, and insureds from those who would conceal significant facts relevant to their insurability.

MIB, Inc. – Information regarding your insurability will be treated as confidential. PL or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have about you in its file. Please contact MIB at [866-692-6901 (TTY 866-346-3642)]. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

PL, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Investigative Consumer Report – As part of our underwriting procedure, we may request an investigative consumer report from a consumer reporting agency. A consumer report confirms and supplements the information on your application pertaining to employment and residence verification, smoking habits, marital status, occupation, hazardous avocations, and general health. This report may also cover information concerning your general reputation, personal characteristics, and mode of living (**except as may be related directly or indirectly to your sexual orientation**) including drug and alcohol use, motor vehicle driving record, and any criminal activity. This information may be obtained through personal interviews with you, your family, friends, neighbors, and business associates. If a report is required and you wish to be personally interviewed, please let us know and we will notify the consumer reporting agency. The information contained in the report may be retained by the consumer reporting agency and subsequently disclosed to other companies to the extent permitted by the Fair Credit Reporting Act. Investigative consumer reports are held in strict confidence and used only to evaluate your application on a fair and equitable basis. You have a right to inspect and obtain a copy of the report from the consumer reporting agency.

DISCLOSURE TO OTHERS

Personal information obtained about you during the underwriting process and at other times is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business and only to the extent permitted by applicable state law. Examples of situations where we may share information about you are as follows:

- The Insurance Professional may retain a copy of your application, and if a policy is issued will have access to ongoing policy information to better serve your needs.
- If reinsurance is required, the reinsurance company would have access to our application file.
- We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized it to obtain such information.
- As stated earlier, we may report information to the MIB.
- We will disclose information to government regulatory officials, law enforcement authorities, and others where required by law.

DISCLOSURE TO YOU

In general, you have a right to learn the nature and substance of any personal information about you in our file upon written request. Whenever an adverse underwriting decision is made, we will notify you of the reason(s) for the decision and the source of the information upon which our action is based. Medical record information, however, will normally be given only to a licensed physician of your choice. Please refer to the section on MIB, for that organization’s disclosure procedure. Should you feel that any information we have is inaccurate or incomplete, please write to: Manager, New Business Services, Pacific Life Insurance Company, [P.O. Box 2030, Omaha, NE 68103-2030]. Your comments will be carefully considered and corrections made where justified. We hope this Notice will help you to understand how we obtain and use personal information in the underwriting process, and the ways you can learn about this information. We are concerned with insuring privacy as well as lives, and the collection, use, and disclosure of personal information is limited as specified in this Notice.

PACIFIC LIFE INSURANCE COMPANY

[Life Insurance Operations Center
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(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com]

**PACIFIC LIFE****PRODUCER REPORT – TERM INSURANCE**

Proposed Insured's Name: First MI Last **Date of Birth** (mm/dd/yyyy)

SOLICITATION INFORMATION (To be answered by Soliciting Producer. Explain all "Yes" answers in Remarks unless instructed otherwise.)

1. Did you personally meet with all parties who have signed this application and ask the appropriate parties all applicable questions in this application?
☐ Yes ☐ No (If No, explain in Remarks)
2. Indicate the form of valid identification used to confirm the identity of each person signing this application. (Check all that apply)

Individual Person		Non-Individual Entity	
<input type="checkbox"/> Driver's License	<input type="checkbox"/> Passport	<input type="checkbox"/> Business License	<input type="checkbox"/> Trust Document
<input type="checkbox"/> Government Issued Photo ID	<input type="checkbox"/> _____	<input type="checkbox"/> Certified Articles of Incorporation	<input type="checkbox"/> _____
		<input type="checkbox"/> Partnership Agreement	

3. Has the Proposed Insured changed his/her name during the past 5 years?
☐ No ☐ Yes If Yes, give former name(s) and reason: _____
4. Are you related to the Proposed Insured? ☐ No ☐ Yes If Yes, give details: _____
5. Is the Proposed Insured dependent on anyone for their source of support? ☐ No ☐ Yes

6. Are you aware of any information not given in the application that might affect the insurability of the Proposed Insured?
7. Certain states require replacement forms for any in force policies even if a replacement is not intended.
- A. Is there any existing or pending life insurance or annuity on the Proposed Insured?
- B. To the best of your knowledge, will the policy applied for replace, cause a change in, or involve a cash withdrawal or loan from or lapse of any life insurance policy or annuity on the Proposed Insured's life or in any life insurance or annuity owned by the Applicant, or is the Policyowner considering using funds from existing policies to pay premiums on the new policy?
- C. I have discussed the appropriateness of replacement, and followed applicable state laws, Pacific Life's written replacement guidelines and, if applicable, I have complied with the replacement requirements of my broker-dealer. (If No, explain in Remarks)
8. Have plans been made that any other party (including a Life Settlement and/or Viatical Company), other than the Policyowner, will obtain any right, title or interest in any policy issued on the life of the Proposed Insured as a result of this application?
9. Check appropriate items that have been ordered:

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

☐ Paramedical Exam ☐ H.O. Specimen ☐ EKG ☐ APS _____
☐ Blood Profile ☐ Medical Exam ☐ Inspection Report _____ Facility/Physician Name

PURPOSE FOR PURCHASE OF LIFE INSURANCE (Complete #1 or 2, whichever is applicable)

1. Personal Insurance: ☐ Estate Planning ☐ Income Replacement ☐ Other _____
- 2A. Business Insurance: ☐ Buy-Sell ☐ Key Person ☐ Section 79: # of Participants _____ ☐ Other _____
- B. Type of business: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other: _____

C. Total Business Assets \$ _____ D. Total Business Liabilities \$ _____ E. Total Business Net Worth \$ _____

F. Net Income (Profit) for the past 2 years: Last Year: \$ _____ Previous Year \$ _____

G. List the business insurance in force and applied for on each corporate officer, key person or partner. If none, explain in Remarks.

Name	Title or Position	% of Business Owned	Amount In Force	Amount Applied For
			\$	\$
			\$	\$

H. If any officer, partner or key person is not proportionately insured, explain.



PRODUCER COMMISSION INFORMATION (If more than three Producers, use Remarks. SAID Code is assigned by Pacific Life.)**SERVICING PRODUCER'S INFORMATION**

Name: First	MI	Last	SAID Code	RLO or PL Servicing Office #	Commission %
Soc. Sec. # / Tax ID #	E-mail Address		Telephone # (include area code)	Fax # (include area code)	

ADDITIONAL PRODUCER

Name: First	MI	Last	SAID Code	RLO or PL Servicing Office #	Commission %
Soc. Sec. # / Tax ID #	E-mail Address		Telephone # (include area code)	Fax # (include area code)	

ADDITIONAL PRODUCER

Name: First	MI	Last	SAID Code	RLO or PL Servicing Office #	Commission %
Soc. Sec. # / Tax ID #	E-mail Address		Telephone # (include area code)	Fax # (include area code)	

REMARKS**SOLICITING PRODUCER'S CERTIFICATION**

I certify that to the best of my knowledge and belief:

1. I have presented to the Company all pertinent facts and have correctly and completely recorded all required answers.
2. I have given the Proposed Insured a copy of the Disclosure Notice, and any other disclosure notice, statement or information required by state or federal law.
3. If applicable, I have fully explained the terms and conditions of the Temporary Insurance Agreement to all parties and I have provided a copy to all parties.
4. I have complied with all applicable state and/or federal laws in the recommendation and/or sale of this policy. I have also complied with Pacific Life's procedures on cost comparison, illustration, and replacement.
5. I have reviewed this Application, and have determined that its proposed purchase is suitable as required under law, based in part upon information provided by the Applicant, Policyowner and Proposed Insured, as applicable, including age, income, net worth, tax and family status, and any existing insurance program.
6. Only sales materials provided or otherwise approved by Pacific Life were used in the sales process and copies of all sales material were left with the applicant.
7. I am appropriately state licensed and appointed in all jurisdictions in which sales activity (including solicitation, obtaining application signatures, and policy delivery) related to this application has taken or will take place.
8. If any person is an active duty member of the United States Armed Forces (including active duty military reserve personnel), I certify that this application was not solicited and/or signed on a military base or installation, and I provided to the applicant the disclosure required by Section 10 of the Military Personnel Financial Services Protection Act.

Signed and Dated by the Soliciting Producer on: _____ (mm/dd/yyyy)

**X**

MUST MATCH THE SOLICITING PRODUCER ON THE APPLICATION'S SIGNATURE PAGE.

Soliciting Producer's Signature

ADDITIONAL PRODUCER'S CERTIFICATION (Required if personally meeting with the client during solicitation or policy delivery.)

I am appropriately state licensed and appointed in all jurisdictions in which sales activity (including solicitation, obtaining application signatures, and policy delivery) related to this application has taken or will take place.

Signed and Dated by the Additional Producer(s) on: _____ (mm/dd/yyyy)

**X****X**

Additional Producer's Signature

Additional Producer's Signature

Statement of Variability
Policy Form P10IRT

Location	Factor	Sample Value	Range		Conditions
Cover Page	Insured	LELAND STANFORD	Insured's Name		Applicant Choice
Cover Page	Sex and Age	MALE 35	Male, Female, Unisex Issue ages 20-75		Administrative system assigns
Cover Page	Risk Class	STANDARD NONSMOKER	Nonsmoker Super Preferred Preferred Plus Preferred Standard	Smoker Preferred Standard	Determined by the underwriter.
Cover Page	Policy Number	1AXXXXXXXX	Administrative system assigns		Administrative system assigns
Cover Page	Policy Date	October 1, 2009	Date policy is in force		Administrative system assigns
Initial Monthly Benefit*	Face Amount	\$5000.00	\$2000.00 - \$50,000.00		Depends on level or increasing premium and applicant choice
Initial Total [Monthly Premium]	Monthly Benefit	\$120.78	None		Depends on monthly benefit and premium mode
Cover Page	Owner	LELAND STANFORD	Owner's Name		Applicant Choice
Cover Page	Free Look	20 days	30 days if replacement policy		Determined by whether policy issued is replacement or not
Page 3.0 – 4.2	Policy Number	1AXXXXXXXX	Administrative system assigns		Administrative system assigns
Page 3.0	Requested Premium Payment Interval	Monthly	Annual, Semi-Annual, Quarterly or Unichex		Applicant Choice
Page 3.0	Initial Total Premium	\$120.78	None		Depends on monthly benefit and premium mode
Page 3.0	Level Premium Period End Date	October 1, 2039	N/A		Ends at attained age 65
Page 3.0	Expiration Date	October 1, 2069	N/A		Ends at attained age 95
Page 3.1 - 4.2	Insured	LELAND STANFORD	Insured's Name		Applicant Choice

Statement of Variability
Policy Form P10IRT

Page 3.1	Sex and Age	Male 35	Male, Female, Unisex Issue ages 0-90		Applicant Choice
Page 3.1	Risk Class	STANDARD NONSMOKER	<u>Nonsmoker</u> Super Preferred Preferred Plus Preferred Standard	<u>Smoker</u> Preferred Standard	Determined by the underwriter.
Page 3.1	Rider	R10ALB	This is either present or it isn't		Present if selected by applicant.
Pages 4.0 – 4.1	Table of Premiums at Annual Intervals for Basic Coverage	\$1,342.05 - \$142,268.97	Premiums vary based upon Rate Classification and Premium not.		Calculated by the system
Page 4.2 – 4.3	Table of Initial Monthly Benefits	\$5,000.00 - \$5,350.00	Level Monthly Benefits *Note: the insured may choose between Level monthly benefits and 3% Increasing monthly benefit. This table will be present only if Level monthly benefits are chosen		Calculated by the system
Page 4.2 – 4.3	Table of Initial Monthly Benefits	\$5,000.00 - \$29,172.00	3% Increasing Monthly Benefits *Note: the insured may choose between Level monthly benefits and 3% Increasing monthly benefit. This table will be present only if 3% Increasing monthly benefits are chosen		Calculated by the system

Statement of Variability
A10TRM

Page	Location	Current Content	Future Content
1	Right Header	Current company mailing address	Future company mailing address
1	Policy Information #4	Current additional benefits	Future additional benefits available

PACIFIC LIFE INSURANCE COMPANY

Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • fax (949) 462-3066
www.Pacificlife.com



DISCLOSURE STATEMENT TO ADD ACCELERATED LIVING BENEFIT RIDER

Insured's Name: First MI Last	Policy Number:
Applicant/Owner's Name (if other than Insured)	

This Disclosure Statement provides a brief summary of the important features of an Accelerated Living Benefit Rider. It does not alter any of the rider's provisions.

1 ELECTION OF AN ACCELERATED LIVING BENEFIT RIDER FOR A NEW POLICY

- ☐ Check here if you wish to add the Accelerated Living Benefit Rider to your new policy.

Be sure to indicate your election of the Accelerated Living Benefit Rider on the application.

FOR AN EXISTING POLICY

- ☐ Check here if you wish to add the Accelerated Living Benefit Rider to your existing policy.

Add to policy number _____

2 GENERAL INFORMATION

WHAT IS AN ACCELERATED LIVING BENEFIT

- If the insured is diagnosed with a terminal illness, a Living Benefit is the benefit available under a life insurance policy while the insured is still living, subject to our approval.
- WE WILL ONLY PAY THE BENEFIT AVAILABLE UNDER THIS RIDER ONCE.

TAX CONSEQUENCES

- **UNLIKE CONVENTIONAL LIFE INSURANCE PROCEEDS, A LIVING BENEFIT MAY BE TAXABLE.**
- **A QUALIFIED PERSONAL TAX ADVISOR SHOULD BE CONSULTED BEFORE REQUESTING A LIVING BENEFIT PAYMENT.**

COST

- There is no additional premium charged to add an Accelerated Living Benefit Rider to a life policy.
- Currently, there is no fee to exercise this rider, but we reserve the right to charge a processing fee, not to exceed \$150.00.

OTHER OPTIONS

- An Accelerated Living Benefit Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so.
- Alternatively, you may elect to receive a loan (if available under your policy) or surrender your policy.

LIMITS OF AN ACCELERATED LIVING BENEFIT RIDER

- This Accelerated Living Benefit Rider is NOT Health, Nursing Home or Long Term Care Insurance, and it is not intended or designed to eliminate your need for such coverage. There are no restrictions or limitations on the use of the Living Benefit Payment.
- Receipt of the Living Benefit Payment under this rider MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME (SSI) eligibility. Exercising the option to accelerate and receive benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Department of Public Welfare and Social Security Administration Office for more information.

EFFECT OF A LIVING BENEFIT PAYMENT ON MY POLICY

- After a Living Benefit Payment is made, the policy will remain in force and any required premiums payable will be reduced. The policy death benefit, any cash value, paid-up additions, Accumulated Value, if any, and any term insurance rider eligible to be accelerated under this rider will be reduced by the Requested Percentage. (NOTE: the face amount of any scheduled increase(s) in insurance as provided by an additional benefit rider during the 12 month period after the date the accelerated proceeds are requested, will not be included when determining the Eligible Coverage).
- Any outstanding policy loan will be reduced by the portion of the policy loan which is repaid.
- Any adjustment in Accumulated Value will be allocated as applicable to the Fixed Accounts and Variable Accounts on a prorata basis.
- Any Cost of Insurance Charges will be adjusted to reflect the reduction in death benefit.
- When a Living Benefit Payment is made, we will notify the owner of the revised policy values then in force.



DISCLOSURE STATEMENT TO ADD ACCELERATED LIVING BENEFIT RIDER

**PACIFIC LIFE**

Insured's Name: First MI Last

Policy Number:

3 SAMPLE ILLUSTRATION

Here is an example of how a Living Benefit Payment will affect a policy:

OWNER REQUESTS AN ACCELERATED BENEFIT OF \$100,000.		
	BEFORE	AFTER
POLICY DEATH BENEFIT:	\$200,000	\$100,000
ANNUAL PREMIUM:	\$3,750	\$1,900
OUTSTANDING POLICY LOAN:	\$10,000	\$5,000
CASH VALUE:	\$89,000	\$44,500

Adjustment for Interest: 5.0%

The amount of the Living Benefit Payment is computed as follows:

Requested Portion amount less loan repayment, less adjustment for interest* = Living Benefit Payment.

\$100,000.00 - \$5,000.00 - \$1,350.04 = \$93,649.96

*The adjustment for interest is explained in the rider and represents a 5% annual interest discount on the early payout of the Living Benefit Payment.

4 SIGNATURES

I hereby acknowledge that I have received and read this living benefit disclosure summary. I have also indicated in Section 1 if I elect the Accelerated Living Benefit Rider.

Insured's Signature	Date
Applicant/Owner's Signature (if other than Insured)	Date
Producer's Name: First MI Last	
Producer's Signature	Date

INSTRUCTIONS

When to use this form:

This form is used when adding the Accelerated Living Benefit Rider at the time of application or to an in-force policy.

Who must sign this form:

INSURED – Required signature.

APPLICANT/OWNER(S) – Required signature, if other than insured.

PRODUCER – Required signature.

Where to send this form:

Send this form to Pacific Life Insurance Company, Attn: Life Insurance Operations Center, P.O. Box 2030, Omaha, NE 68103-2030. Our toll free number is (800) 347-7787.

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.

<i>SERFF Tracking Number:</i>	<i>PALD-126375439</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pacific Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44173</i>
<i>Company Tracking Number:</i>	<i>P10IRT</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life</i>
<i>Product Name:</i>	<i>P10IRT</i>		
<i>Project Name/Number:</i>	<i>P10IRT/P10IRT</i>		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/20/2009	Form	Foreign Residence/Past and Future Foreign Travel Questionnaire	11/30/2009	A10TPF.pdf (Superceded)

PACIFIC LIFE INSURANCE COMPANY

Life Insurance Operations Center
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 964-4860
www.PacificLife.com

**PACIFIC LIFE****FOREIGN RESIDENCE AND TRAVEL QUESTIONNAIRE – PAST AND FUTURE****PROPOSED INSURED**

Name: First	MI	Last	Policy Number
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FOREIGN RESIDENCE (Complete this section if your primary residence is outside of the United States, Canada, Guam, or Puerto Rico.)

Primary Residence: City	Country	How Long? yr mo
Secondary Residence: City	Country	How Long? yr mo

If you expect to do any additional traveling while residing abroad complete the Future Travel section.

Past Travel (Complete this section for all travel outside the United States (or your country of residence) for the last 3 years. Use separate sheet if

	Trip 1		Trip 2		Trip 3	
Country Name						
City(ies) or Region Expected to Visit						
Length of Stay	___ Days ___ Weeks ___ Months		___ Days ___ Weeks ___ Months		___ Days ___ Weeks ___ Months	
Dates	From	To	From	To	From	To
Purpose of Trip:	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:	

Continued...

FOREIGN RESIDENCE AND TRAVEL QUESTIONNAIRE – PAST AND FUTURE (Continued)

Future Travel (Complete this section for all intended travel outside the United States (or your country of residence) for the **next** 3 years. Use a separate sheet if necessary.)

	Trip A		Trip B		Trip C	
Country Name						
City(ies) or Region Expected to Visit						
Number of Trips						
Length of Stay	____ Days ____ Weeks ____ Months		____ Days ____ Weeks ____ Months		____ Days ____ Weeks ____ Months	
Expected Dates	From	To	From	To	From	To
Accommodations:	<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____		<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____		<input type="checkbox"/> Hotel <input type="checkbox"/> Staying with family <input type="checkbox"/> Other _____	
Purpose of Trip:	<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:		<input type="checkbox"/> Personal <input type="checkbox"/> Business <input type="checkbox"/> Missionary Details:	

SIGNATURES

I represent that the foregoing answers and statements are correctly recorded, complete, and true to the best of my knowledge and belief.

SIGNED AND DATED ON:

Date (mm/dd/yyyy)



X

Proposed Insured's Signature

INSURANCE PROFESSIONAL: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES.